FN-0156-1098

COBRA NOTICE
CONTINUATION OF THE STATE OF NEW JERSEY UNREIMBURSED MEDICAL SPENDING ACCOUNT PLAN

This form is to be completed by the benefits administrator

To the Family of

_____ Notice Date: _____

_____ Employer Name: _____

_____ Payroll #: _____

_____

SSN _____

Dear Employee and/or Family Member(s):

Your State of New Jersey Unreimbursed Medical Spending Account (UMSA) coverage ends on the date shown below because of a change in employment status or dependent eligibility. The reason for the loss of coverage and the last date of coverage are also shown below. Under the provisions of the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA), you are entitled to continue this benefit for a limited time, also shown below.

DATE OF COBRA EVENT: _____

COBRA EVENT: (Check one)

☐ Termination of employment ☐ Reduction in hours ☐ Leave of absence

☐ Death of employee ☐ Divorce or separation ☐ Dependent ineligibility

LAST DATE OF COVERAGE: _____ COBRA CONTINUATION TERM _____

You may continue your contributions to the Unreimbursed Medical Spending Account (UMSA) with after tax dollars for the time period shown in the COBRA Continuation Term or until one of the following occurs: (1) you voluntarily cancel your coverage, (2) you fail to make your contributions in a timely manner; (3) you become covered under another employer's plan after electing COBRA coverage; or (4) the State ceases to offer this plan to its employees.

ANNUAL UMSA ELECTION: $_____ PAY PERIOD DEDUCTION $_____

You, and each of your dependents separately, have the right under COBRA to continue the full amount of the annual benefit by continuing to pay for this coverage. **You have 60 days from the date of this notice or the last date of coverage, whichever is later, to elect to continue coverage.** You elect coverage by completing the COBRA UMSA Election Form on the reverse side of this Notice and returning it to the address provided. Failure to elect coverage during this period is considered a decision not to elect coverage. If you elect to continue coverage, a single monthly payment of $_____ (2 X pay period deduction x 102%) will be required, and will cover expenses for you and your dependents. If you do not elect to continue coverage, your spouse or other eligible dependent(s) can do so collectively as a family or individually.

We must receive your payment within 45 days of the date you sign the Election Form. The initial premium payment will be applied to the period beginning the day after the last date of coverage shown above. If any of your payments are not received by the due dates, you will lose your option to continue coverage. You will be provided a grace period of thirty days in which to pay premiums due.

SIGNATURE OF BENEFITS ADMINISTRATOR _____ DATE _____